DBHS Form 6

ARKANSAS DEPARTMENT OF HUMAN SERVICES

DIVISION OF BEHAVIORAL HEALTH SERVICES

RSPMI ANNUAL REPORTING FORM

State Fiscal Year 20XX: 7/01/XX through 6/30/XX

Name of Agency: _____

Chief Executive Officer (or equivalent): _____

Corporate Compliance Officer (or equivalent): _____

Address: _____

Phone Number :_____ Fax Number: _____

E-Mail:

Provider Type: Private Non-Profit _____ Private For Profit _____ Public Entity _____

Other (Specify): _____

Chief Executive Officer Certification (or equivalent): By my signature I certify that I have reviewed this report and attachments and to the best of my knowledge it represents an accurate report of agency services and resources.

_____ _____

Signature of Chief Executive Officer (or equivalent) Date

_____

Name of Chief Executive Officer (or equivalent) typed or printed

THIS REPORT RELATES TO AGENCY WIDE INFORMATION

1. Please include all annual reporting requirements from the accrediting organization. This includes Annual Conformance to Quality Report, Maintenance of Accreditation or Periodic Performance Review. Please include all correspondence to and from the accrediting organization related to annual reporting requirements.

2. **RSPMI services provided at the agency (Please check all that apply):**

Individual Therapy ☐
Family Therapy ☐
Group Therapy ☐
Rehabilitative Day Treatment ☐
Adults ☐ U-21 ☐

Crisis Services ☐
Acute Day Treatment ☐
Adults ☐ U-21 ☐
Residential Programs ☐
Adults ☐ U-21 ☐

Medication Management ☐
Psychological Evaluation ☐
After School Programs ☐
Other ☐
(Please Explain):

MHPP Case Management ☐
School Based ☐
School Linked ☐

_____

_____

_____

3. Provider's plans and activities to overcome cultural and linguistic barriers to treatment. (Please include a brief statement regarding on-going efforts to serve clients from diverse backgrounds as well as those clients that may have physical disabilities.)

3. **Staff Composition (Please fill out the following chart)**
THIS INFORMATION RELATES TO AGENCY WIDE INFORMATION
PERSONNEL RESOURCES
(As of the date this report is submitted, report the number of full time employees [FTE] or round to nearest tenth) For example: a half-time employee would be .5 FTE

	TOTAL	W-9 or 10-99
1. FTE Mental Health Professional (MHP) Psychiatrists:		
2. FTE MHP non-psychiatrist Physicians		
3. FTE MHP Psychologists		
4. FTE MHP Psychological Examiners		
5. FTE MHP Psychological Examiners, Independent		
6. FTE MHP Master of Social Work		
7. FTE MHP Registered Nurses		
8. FTE MHP Licensed Professional Counselors		
9. FTE MHP in Related Professions		
10. FTE Mental Health Professionals (Sum of lines 1-9)		
11. FTE Mental Health Paraprofessionals		
12. FTE all other staff not included above		
13. FTE staff (Sum of lines 9, 10 and 12)		
14. FTE mental health professional case managers		
15. FTE mental health paraprofessional case managers		
16. Total FTE providing employment services (Other than assessment as part of routine evaluations)		
17. FTE providing psychosocial rehabilitative day services		
18. FTE providing acute day treatment services		

5. **Interagency involvement** (Please identify all existing formal or informal contracts the agency has with other providers or agencies to provide RSPMI services. Briefly explain how the agency utilizes and interfaces with other community resources to provide services for the recipient to reinforce the agency's efforts to support Recovery Model and System of Care philosophies.)

6. **Agency wide quality improvement and outcomes activities** (Please include agency organizational chart and the outcomes of identified quality improvement efforts to improve client care/outcomes.)

PLEASE SUBMIT THIS FORM AND INFORMATION TO:

Division of Behavioral Health
Policy & Certification Office
305 South Palm Street
Little Rock, AR 72205

FOR DBHS INTERNAL USE ONLY:

1) Services Provided Status: Complete	Yes ___ No ___
2) Cultural/Linguistic Barriers Status: Complete	Yes ___ No ___
3) Staff Composition Status: Complete	Yes ___ No ___
4) Interagency Involvement Status: Complete	Yes ___ No ___
5) Quality Improvement Status: Complete	Yes ___ No ___
6) ACQR MOA PPR	Yes___ No ___

Comments: